Volume 7, No. 1, January 2001

A Review of the Surgeon General's Report on Oral Health

What is the U. S. Government doing to us? On Thursday, May 25, 2000 the Surgeon General of the United States, David Satcher released his Report on Oral Health in America at the Shephard Elementary School in Washington, D. C.

Can you imagine The Assistant Secretary for Health and the Surgeon General of the United States working from the Office of Public Health and Science releasing a 332 page report on oral health at an elementary school? Yes, an elementary school; not a university, not a college of dentistry, not at a national meeting of the American Dental Association or the Academy of General Dentistry, but at an elementary school in Washington, D. C.!

As Doctor Satcher wrote in his Preface to the Report, it would "inform the American people about the opportunities to improve oral health and provide a platform from which the science base for craniofacial research can be expanded." He further told the students that "The report should also serve to strengthen the translation of proven health promotion and disease prevention approaches into policy development, health care practice, and personal lifestyle behaviors." Good stuff for grade school kids.

Background

The report was prepared by a project team comprised of three dentists: one from the Los Angeles County Department of Health Services; one from the National Institute of Dental and Craniofacial Research in Bethesda, Maryland; and one from the Centers for Disease Control and Prevention in Atlanta, Georgia. Of the 81 contributors to the Report, 37 emanated from agencies of the U. S. Government. These preparers and contributors were supported by a Federal Coordinating Committee comprised of 22 individuals working within the government, 6 of whom were dentists. The Report was reviewed by 124 persons including 8 deans of dental schools and at least 5 former deans of dental schools, many others from dental school faculties, many from various government agencies and even 9 of whom were identified as being dentists in private practice.

What is so important about all of this? Should we (as dentists and specialists in dentistry) be interested? Should we be informed about the Report? Should we care?

Well, for starters, in review of a transcript of Dr. Satcher's remarks that day at the elementary school he didn't use the word dentist, dental specialist or dentistry one time. He got close one time when he mentioned "oral health services." To our credit, he did mention that "the plates [yes, plates] of George Washington were carved from walrus tusk." He even went on to use Washington's poor dental experience to underscore a direct relationship between poor oral health and poor overall health.

To dentistry's discredit, he cited statistics that emphasized a "silent epidemic" of dental and oral diseases across the country. He told the children that tooth decay is currently the single most common chronic childhood disease today. He also told them that 30,000 oral and pharyngeal cancers are diagnosed in Americans each year, accounting for 8,000 deaths. He stressed that one in four Americans between the ages of 65 and 74 have severe periodontal disease. And finally that oral clefts are one of the most common birth defects in the United States. He coupled those fears with the fact that only 60 per cent of baby boomers receive dental insurance through their employers, and that most older workers *please continue to page 2.*

lose their dental insurance at retirement. In addition, he wanted them to know that uninsured children are two and one-half time less likely to receive dental care than insured children. He said too that children from families without dental insurance are three times as likely to have dental needs compared to their insured peers. This all must have been quite comforting to the elementary school children in the audience!

The Report's Basic Concept

Those of us on the high end of the professional spectrum, i.e. specialists performing value-added treatments, will have a tough time accepting this study's primary concept. The study's basic concept is all of dentistry's personnel, facilities and treatments should be spread equally to all of the population, "removing barriers between people and oral health services." Said another way, each segment of the population, rich or poor or middle class should receive equal treatments or oral health care as the Report likes to call it. The actual words in the Executive Summary are:

> "Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health. The public health capacity for addressing oral health is dilute and not integrated with other public health programs. Although the Healthy People 2010 objectives provide a blueprint for outcome measures, a national public health plan for oral health does not exist. Furthermore, local, state, and federal resources are limited in the personnel, equipment, and facilities available to support oral health programs. There is also a lack of available trained public health practitioners knowledgeable about oral health. As a result, existing disease prevention programs are not being implemented in many communities, creating gaps in prevention and care that affect the nation's neediest populations. Indeed, cutbacks in many state budgets have reduced staffing of state and territorial dental programs and curtailed oral health promotion and disease prevention efforts. An enhanced public health infrastructure would facilitate the development of strengthened partnerships with private practitioners, other public programs, and voluntary groups.

When hearing this for the first time one would have to ask is an effective health infrastructure that meets the oral health needs of all Americans the same as <u>American dentistry</u>? Has organized American dentistry been derelict in its obligations to society? Have we neglected and ignored those in need, taken our money from those who could afford dentistry and left others in want? Have we fattened ourselves and selfishly taken only what benefited ourselves? Is American dentistry is sitting helplessly by, ineffective, awaiting the government to step in and address critical needs as they see them?

The Need for Social Engineering

The Executive Summary's authors see the oral health work force in racial and ethnic terms. They see social engineering as a means to correct society's diversity ills. The government's soothsayers observe that:

> "There is a lack of racial and ethnic diversity in the oral health work force. Efforts to recruit members of minority groups to positions in health education, research, and practice in numbers that at least match their representation in the general population not only would enrich the talent pool, but also might result in a more equitable geographic distribution of care providers. The effect of that change could well enhance access and utilization of oral health care by racial and ethnic minorities.
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> "A closer look at trends in the work force discloses a worrisome shortfall in the numbers of men and women choosing careers in oral health education and research. Government and private sector leaders are aware of the problem and are discussing ways to increase and diversify the talent pool, including easing the financial burden of professional education, but additional incentives may be necessary."

Isn't it interesting; the Marine Band's recruiting posters are saying the same thing!

The Need For Dental Insurance

A problem even more worrisome to them is the lack of dental insurance, which they see as an impediment to obtaining oral health care. Their solution to this problem is the use of public private partnerships made up of public health agencies, private industry, social services organizations, educators, health care providers, researchers, the media, community leaders, voluntary health organizations and consumer groups, and concerned citizens. The bottom line is the development of a National Oral Health Plan to improve quality of life and eliminate health disparities. Again, what is the reason they

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haven't specifically put dentistry, dentists, and organized dentistry at the head of the list?

The Need for Research

Another crisis the Executive Summary mentions is the need for the nation's continued investment in research, which they say is critical for the provision of new knowledge about oral health care and general health. They cite an overall need for behavioral and clinical research, clinical trials, health services research, and community based demonstration research (whatever that is). Isn't it strange that the PhD. researchers who are the brains behind the Report are calling for research in their own very areas of expertise? Have they been neglecting or overlooking their own responsibilities? Or is it that in the search and justification for research monies, they rather think their own areas of study are more important than dental research or research in the basic sciences? Or do they know that only so much money will be allocated by Uncle Sam and they want to be first up for the dole?

The Need to Understand the Relationship Between Oral Health and General Health and Well-Being

The Report's chapter 5 is an enigma. It's 37 pages and its 287 references serve as a potent literature review of the connections between oral conditions and HIV infection, osteoporosis, bacteremia, infective endocarditis, and respiratory diseases. The chapter also discusses the use of salivary secretions to detect systemic diseases and the consequences to the oral tissues when chemotherapies, radiation therapies and pharmaceuticals are used systemically. A periodontal disease connection to diabetes; an oral infection connection to heart disease and stroke; and the periodontal disease and adverse pregnancy outcomes are thoroughly reviewed. Anyone teaching, involved in clinical practice and preparing for the specialty board would be well advised to study this chapter, and especially look over the list of references for further investigation.

Conclusions drawn from the literature were:

•The relationship of periodontal disease and diabetes shows the strongest evidence of connection, but the effect of periodontitis on glycemic control is less clear.

•None of the reviewed studies achieved the level of rigor necessary to unequivocally establish periodontitis as an independent risk factor for cardiovascular disease or stroke.
A newer study, not in the Report, from SUNY Buffalo looking at 9962 people between the ages of 25 and 74 found that people with periodontitis had almost twice the risk of stroke. This study maybe flawed, but can be checked at:
http://archinte.ama-assn.org

•And finally, periodontal disease as a remote gram-negative infection may have the potential to affect pregnancy outcome.

The puzzle of Chapter 5 is why was it written and to whom was it directed? Was its purpose to wake physicians up? Was it to inform lay people? Was it to lay groundwork for a crisis, at which politicians could throw money? Frankly there was nothing new for dentists who keep current with the literature, and much of what was said lies in today's dental school curricula. Their solutions to the problems are simplistic and treat dentistry in a condescending manner. It's like we have done nothing, are vague in our research and that we need help badly. What good does it do to ask for:

•Larger cross-sectional studies, as well as longitudinal and mechanism studies?

•A better understanding of the role of the oral cavity and its components in protecting against infection?

•An awareness of the oral complications of medications and other therapies for disease management?

•A consideration of the side effects of new drug and biologics being developed?

And in other chapters did you know:

•That both dental and systemic diseases can profoundly affect the appetite?

•That a number of studies have indicated that having missing teeth is linked to a quantitatively poorer appetite? *continue to page 4*

•That clinical research has demonstrated a general reduction in the chewing function as the number of missing teeth increases?

•That in some studies of prosthodontic treatment, self-reported chewing ability improved following treatment?

Really, let's waste no more or our time! Dentistry and it's specialty of prosthodontics isn't asleep! To raise these issues as if we were ignoring our responsibilities is quite insulting, especially in consideration of dentistry's stellar history in its record of academic accomplishment, and the reams of statistics that document the worth of dentistry's public health initiatives in improving the oral health of the population in general!

It was a terrible waste of money and time for all involved in this project to simplistically state what dentistry is, to describe the oral cavity in detail (chapter 2.), to recite all oral infectious and cancerous conditions (chapter 3.) and to explain what "provider-based"care is.

First Do No Harm

It took 243 pages to get to what may be important: — "What are the needs and opportunities to enhance oral health?"— and they took only 44 more pages to lay out the future! This milestone in the history of oral health, as they describe it, turns out to be a millstone around the necks of all American dentists.

With hands-on, who will recognize and treat the problems of the mouth? Their definition of the mouth includes not only the teeth and gums [gingiva], but also "the hard and soft palate, the mucosal lining of the mouth and throat, the tongue, the lips, the salivary glands, the chewing muscles, and the upper and lower jaws. Equally important are the branches of the nervous, immune, and vascular systems that animate, protect, and nourish the oral tissues, as well as provide connections to the brain and the rest of the body." Who is and will treat this same mouth that the physicians have long overlooked and the mouth the clinical psychologists have used only as a study ground and as a means for keeping their offices full of paper?

Dentists and specialists in dentistry will treat the mouth, with no apology to make, especially when the Report elucidates historical models of oral health care by using 50+ non-dentist references. We have been there and done that, and a safe prediction for. future success will be:

a dentist standing (or sitting) at the chair directly treating oral tissue problems <u>and</u> a dentist directing auxiliaries in support of direct patient treatment <u>and</u> a dentist at an elementary school doing gratis examinations and instructing children in oral hygiene <u>and</u> dentists volunteering services and equipment and time at charity clinics <u>and</u> dentists teaching in dental schools part time for no pay <u>and</u> dentists going to nursing homes to provide hands-on care in the worst of circumstances <u>and</u> dentists loading planes full of supplies and medications heading voluntarily overseas to spread care and knowledge about dentistry in third world countries

and dentists will be the final, total and complete answer to the problems in oral health care that the physicians and psychologists will find. Oh yes, government assistance will be necessary, but dentists pay taxes too, and so maybe some of their money can be used to their benefit and the benefit of their schools, their research and their patients. Oh yes, the government can be of assistance in pulling the pieces of dentistry together for concerted actions against well identified problems in dentistry. But give us some slack! Dentists will have to be recognized and included, up front, in all aspects of oral health care as the most knowledgeable leaders!

First do no harm? Our physician brothers and our supporting scientists in the basic, clinical and public health arenas have done great harm by not recognizing American dentistry for what it is!

American dentistry is a great and total accomplishment, which has resulted in the best dental and oral health care in the world. It will only get better! ❑